STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING 00 B. WING	06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN 46107

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00108327. This visit was in conjunction with an Investigation of Complaint IN00109515. Complaint IN00108327- Substantiated. Federal/State Deficiencies related to the allegations are cited at F241 and F314. Survey Date: June 4, 5, 6, 7, 8, 9, 11, 12, and 13, 2012 Facility number: 000029 Provider number: 155072 AIM number: 100275200 Survey Team: Beth Walsh, RN-TC Courtney Mujic, RN Karina Gates, Medical Surveyor Census Bed Type: SNF: 18 SNF/NF: 99 Residential:10 Total: 127 Census Payor Type:	F0000	The creation and submission of this Plan of Correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or after July 11, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicare: 26 Medicaid: 71 Other: 30 Total: 127 Residential Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 21, 2012 by Bev Faulkner, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notifying the physician when a resident's pain was unrelieved by multiple use of PRN (as needed) medications for 1 of	F0157	**F157 Notify of Changes in Condition** **It is the practice of this facility to immediately inform the**	07/11/2012

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	3 residents reviewed for pain. (Resident A) Findings include: The clinical record for Resident A was reviewed 6/8/12 at 10:30 a.m. The diagnoses for Resident A included, but were not limited to: compression fracture, back pain, and hip pain. The April, May, and June Physician's Orders indicated an order to take 2 tablets of acetaminophen 325 mg (milligram), by mouth, every 6 hours PRN (as needed) for mild pain or temperature greater than 100 degrees. The Physician's Orders for April, May, and June also indicated an order for 1 tablet of ibuprofen 400 mg to be given every 4 hours PRN for headache. Also, there was an order on the April, May, and June Physician's Orders that indicated that 1 tablet of Pain Reliever Plus (no dosage indicated) was to be taken by mouth every 8 hours PRN for headaches. The following dates on the April, May, and June MAR (Medication Administration Record) indicated that acetaminophen (650 mg) was given:		**resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the faculty as specified in 483.12(a).** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident A's physician was notified of the multiple uses of PRN pain medication. Physician orders will be followed. Pain assessment was completed for this resident. **2. How will you identify other residents having the potential to be affected by these same deficient practices and what corrective action will**	

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	4/2/12, 4/4/12, 4/8/12, 4/13/12, 5/1/12, 5/2/12, 5/3/12, 5/5/12 5/7/12, 5/8/12, 5/9/12 (x 2), 5/11/12, and 6/2/12. On the following dates on the April, May, and June MAR it indicated that ibuprofen 400 mg was given: 4/3/12, 4/4/12, 4/8/12, 4/10/12, 4/11/12, 4/12/12, 4/13/12, 4/15/12, 4/16/12, 4/17/12, 4/18/12, 4/19/12, 4/21/12, 4/24/12, 5/4/12, 5/8/12, 5/9/12, 5/12/12, 5/13/12, 5/25/12, 5/26/12, 6/2/12, 6/5/12, and 6/6/12. The following dates on the April and May Mar indicated the Pain Reliever Plus was given: 4/2/12, 4/3/12, 4/4/12, 4/6/12, 4/10/12, 4/11/12, 4/12/12, 4/13/12, 4/15/12, 4/16/12, 4/17/12, 4/18/12, 4/19/12, 4/21/12, 4/24/12, 5/1/12, 5/2/12, 5/3/12, 5/4/12, 5/5/12, 5/7/12, 5/8/12, 5/9/12, 5/12/12, 5/14/12, 5/18/12, 5/21/12, 5/22/12, 5/23/12, and 5/26/12. An intervention on a care plan for pain, dated 6/23/12, indicated the MD (medical doctor) was to be notified if pain is unrelieved. At 12:55 p.m., on 6/12/12, the DoN indicated the resident's MD had not been notified regarding multiple uses of the PRN medications and that the		**be taken?** All residents have the potential to be affected. In-service is scheduled for nurses on July 10, 2012 to review proper procedure for notifying physician of changes in condition and the proper procedure for assessment of pain before and after PRN medication administration. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/Designee will monitor the MAR M-F for proper documentation related to the assessment of the residents' pain before and after medication administration and to observe for frequency of PRN medication administration. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?**	

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	pain care plan was not followed. 3.1-5(a)(3)		The pain management CQI audit tool will be utilized weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less than 95%. **5. Date facility alleges compliance on July 11, 2012**	

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F0166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on observation, interview, and record review, the facility failed to take action in response to a report of missing clothing for 1 of 3 residents reviewed from the sample of 3 who met the criteria for personal property. (Resident #66) Findings include: During an interview with Resident #66 on 6/6/12 at 10:22 a.m., she indicated earlier in the current year, some of her slacks, shorts and a blouse went missing, was still missing, and that she reported it to the Social Services Director at the time. She indicated that particular Social Services Director no longer worked at the facility. During an interview with the Admissions Director on 6/11/12 at 1:00 p.m., she indicated she was the staff person responsible for investigating missing property and there was no information of any missing clothing for Resident #66, but	F0166	**F166 Right to Prompt Efforts to Resolving Grievances** **It is the practice of the facility to provide a resident a prompt effort by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #66 has had clothing items replaced. **2. How will you identify other residents having the potential to be affected by these same deficient practices and what corrective action will be taken?**	07/11/2012

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	that she would begin an investigation for it. During another interview with Resident #66 on 6/12/12 at 10:38 a.m., she indicated she was certain she reported the missing clothing to the previous Social Services Director and that no one ever followed up with her on the missing clothing. She stated "I never heard anything more about it. They were just gone." The 2/27/12 MDS (Minimum Data Set) assessment for Resident #66 was reviewed on 6/12/12 at 11:00 a.m. The BIMS (Brief Interview for Mental Status) score for Resident #66 was 15 (highest possible score indicating the resident was cognitively intact). During another interview with the Admissions Director on 6/12/12 at 10:49 a.m., she indicated what she thought might have happened, given the intact mental status of Resident #66, was that the previous Social Services Director never passed the grievance regarding the missing clothing onto her for further investigation. She indicated she just went out and bought Resident #66 new clothing to replace her missing clothing. She then raised three		All residents have the potential to be affected. An audit of the facility care/ concern log for outstanding items was conducted. Any outstanding items were addressed within forty-eight hours. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All care/concern items derived from the daily customer care rounds and monthly customer care calls will be recorded on the care/concern log and then channeled to the appropriate department for appropriate action and investigation. The Guest Relations Coordinator or designee will collect the grievance forms and distribute them to the appropriate Department Head. That Department Head or designee will investigate and follow up with the resident, family, staff or other persons involved in the grievance, and that information will be included in the response section of the form. The Department Head will investigate the grievance within 24 hours of receipt and will return to the Guest Relations Coordinator. The Guest	

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	department store bags full of clothing. At this time, three department store bags full of clothing were observed. 3.1-7(a)(2)		Relations Coordinator will coordinate the process to ensure appropriate follow up occurs. The Guest Relations Coordinator will forward the grievance to the Executive Director. After the Executive Director has read and signed acknowledgement of receipt, the Guest Relations Coordinator will contact the resident and/or family to ensure satisfaction with the results of the investigation. Grievances will be completed within 48 hours of receipt. Grievances are discussed during the morning meeting with Department Heads. An in-service is scheduled for July 10, 2012 for the nursing staff and Department Heads on the grievance process. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** The Grievance Resolution CQI audit tool will be utilized weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less than 95%.	

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			5. Date facility alleges compliance on July 11, 2012.	

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure	F0225	**F225 Investigate/Report Allegations/Investigations**	07/11/2012

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	abuse allegations were thoroughly investigated and failed to ensure protection of residents during the initial investigation for 1 of 2 residents that triggered for possible abuse allegations. (Resident #156) Findings include: In an interview with Resident #156 on 6/6/12 at 11:34 a.m., the resident indicated that several staff members were rude to her. The resident gave no further details on the allegation. The above was reported to the DoN (Director of Nursing) on 6/6/12 at 1:10 p.m. The DoN indicated that she was unaware of any staff allegations of rudeness or verbal/mental abuse allegations regarding Resident #156. On 6/8/12 at 1:50 p.m., the DoN indicated that she spoke with Resident #156 on 6/6/12 at approximately 6:00 p.m., and Resident #156 indicated that certain staff members were rude in their actions, which included CNA #6, CNA #7, and LPN #8. The DoN also indicated that the investigation started at that time. The DoN provided a summary of her interviews with CNA #6, CNA #7, and		**It is the practice of this facility to investigate all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident was interviewed related to the allegation and the allegation was reported to the ISDH. Named staff was educated on the resident's specific communication and approach needs. **2. How will you identify other residents having the potential to be affected by these same deficient practices and what corrective action will be taken?**	

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	LPN #8 on 6/11/12 at 3:30 p.m. In the summary provided, it indicated that Resident #156 thought some of the staff members were rude to her. Resident #156 was unable to provide specific details of LPN #8's behavior, but Resident #156 indicated that LPN #8, "does not seem too happy to be here helping me." Resident #156 also indicated that CNA #6, "bosses me around." When Resident #156 was asked specifically how she is bossed around by CNA #6, Resident #156 indicated that CNA #6 tells her to clean off her bedside table for her meal, 20 to 30 minutes prior to meal service. Also, on the summary of the interview, Resident #156 indicated that CNA #7 just comes into her room and stares at her with her meal tray, until Resident #156 cleans off her bedside table. The summary indicated that the DoN interviewed CNA #6 on 6/7/12 (no time indicated). CNA #7 was interviewed on 6/8/12 (no time indicated) and LPN #8 was interviewed on 6/8/12 (no time indicated). Also on her summary, the DoN included the consultation/reeducation that was provided to the above staff members. The Abuse Prohibition, Reporting, and Investigation Policy and Procedure, dated 2/10, was received		All residents have the potential to be affected. Abuse in-servicing was immediately initiated upon notification of the allegation. In-service for staff is scheduled for July 10, 2012 on abuse prevention and the facility's abuse reporting policy and procedure will be discussed. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All abuse allegations moving forward will be investigated and facility abuse policy will be followed. Any named staff in the allegation will be suspended immediately pending results of the investigation per facility policy. Abuse allegation reporting to the ISDH will be initiated within 24 hours of notification of allegations per facility policy. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?**	

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	on 6/12/12 at 11:00 a.m., from the Administrator. The policy indicated that any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed. On a summary of CNA #6, CNA #7, and LPN #8's schedules, provided by the DoN on 6/12/12 at 2:30 p.m., it indicated that CNA #6 worked 6/7/12, 6/8/12, and 6/9/12. The schedule summary indicated that CNA #7 worked 6/8/12 and 6/9/12. LPN #8 worked on 6/7/12 and 6/9/12, as indicated by the summary of worked schedules. At 11:10 a.m., on 6/12/12, the DoN indicated that she did not interview any other residents or staff members about the above staff members to determine if their behavior was a pattern or if any other resident or staff members witnessed the "rude" behavior as indicated by Resident #156, but she will interview residents next time there is any type of an allegation. The DoN also indicated that she interviewed CNA #6 and CNA #7, while they were at work on 6/7/12 and 6/8/12, respectively. On 6/12/12 at 12:55 p.m., the DoN		The Abuse CQI audit tool will be utilized weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less than 95%. **5. Date facility alleges compliance on July 11, 2012.**	

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	indicated that she didn't feel the allegations Resident #156 indicated were abuse, because Resident #156 indicated that CNA #6, CNA #7, and LPN #8 actions were rude, not their voice or tone. The DoN indicated that she would not want to be treated the way Resident #156 was treated. The DoN also indicated again that she was unsure if any resident interviews were completed for the investigation. She thought the Regional Social Services Consultant interviewed residents during their investigation, but the DoN was unsure. The DoN indicated that she does know the facility policy and knows that other residents are supposed to be interviewed. The Regional Social Services interviews were requested at this time. The Abuse Prohibition, Reporting, and Investigation Policy and Procedure also indicated that an investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior and the results will be documented. The investigation will include facts and observations by witnessing non-employees and others who might have pertinent information.			

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	155072	A. BUILDING 00 B. WING	06/13/2012

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	During an interview with the Administrator, on 6/12/12 at 1:35 p.m., he indicated that the investigation process, when an allegation of inappropriate behavior is reported, includes interviewing the resident, interviewing the implicated staff member(s), and interviewing other staff members and residents to determine if the allegation happened or if there is a pattern of inappropriate behavior. The Administrator also indicated that he would not like to be treated as the same way as Resident #156 was and he can see how rudeness can be a form of abuse. He also indicated that he was unsure if any resident interviews were completed for the investigation, but he said he was going to check to see if the Regional Social Services Consultant did some resident interviews. On 6/13/12 at 10:30 a.m., copies of the Facility's Social Services interviews with other residents regarding rude actions by CNA #6, CNA #7, and LPN #8, were provided. 3.1-28(d)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to follow their policy and procedures for thoroughly investigating allegations of abuse and protection of residents during the investigation for 1 of 2 residents that triggered for possible abuse allegations. (Resident #156) Findings include: In an interview with Resident #156, on 6/6/12 at 11:34 a.m., the resident indicated that several staff members were rude to her. The resident gave no further details on the allegation. The above was reported to the DoN (Director of Nursing) on 6/6/12 at 1:10 p.m. The DoN indicated that she was unaware of any staff allegations of rudeness or verbal/mental abuse allegations regarding Resident #156. On 6/8/12 at 1:50 p.m., the DoN indicated that she spoke with Resident #156 on 6/6/12 at approximately 6:00 p.m., and	F0226	**F226 Develop/Implement Abuse/Neglect Policy** **It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident was interviewed related to the allegation and the allegation was reported to the ISDH. Named staff were educated on the resident's specific communication and approach needs. **2. How will you identify other residents having the**	07/11/2012

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	Resident #156 indicated that certain staff members were rude in their actions, which included CNA #6, CNA #7, and LPN #8. The DoN also indicated that the investigation started at that time. The DoN provided a summary of her interviews with CNA #6, CNA #7, and LPN #8 on 6/11/12 at 3:30 p.m. In the summary provided, it indicated that Resident #156 thought some of the staff members were rude to her. Resident #156 was unable to provide specific details of LPN #8's behavior, but Resident #156 indicated that LPN #8 "does not seem too happy to be here helping me." Resident #156 also indicated that CNA #6, "bosses me around." When Resident #156 was asked specifically how she is bossed around by CNA #6, Resident #156 indicated that CNA #6 tells her to clean off her bedside table for her meal, 20 to 30 minutes prior to meal service. Also, on the summary of the interview, Resident #156 indicated that CNA #7 just comes into her room and stares at her with her meal tray, until Resident #156 cleans off her bedside table. The summary indicated that the DoN interviewed CNA #6 on 6/7/12 (no time indicated). CNA #7 was interviewed on 6/8/12 (no time indicated) and LPN #8 was		**potential to be affected by these same deficient practices and what corrective action will be taken?** All residents have the potential to be affected. Abuse in-servicing was immediately initiated upon notification of the allegation. In-service for staff is scheduled for July 10, 2012 on abuse prevention and the facility's abuse reporting policy and procedure will be discussed. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All abuse allegations moving forward will be investigated and facility abuse policy will be followed. Any named staff in the allegation will be suspended immediately pending results of the investigation per facility policy. Abuse allegation reporting to the ISDH will be initiated within 24 hours of notification of allegations per facility policy.	

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	interviewed on 6/8/12 (no time indicated). Also on her summary, the DoN indicated the consultation/reeducation that was provided to the above staff members. The Abuse Prohibition, Reporting, and Investigation Policy and Procedure, dated 2/10, was received on 6/12/12 at 11:00 a.m., from the Administrator. The policy indicated that any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed. On a summary of CNA #6, CNA #7, and LPN #8's schedules, provided by the DoN on 6/12/12 at 2:30 p.m., it indicated that CNA #6 worked 6/7/12, 6/8/12, and 6/9/12. The schedule summary indicated that CNA #7 worked 6/8/12 and 6/9/12. LPN #8 worked on 6/7/12 and 6/9/12, as indicated by the summary of worked schedules. At 11:10 a.m., on 6/12/12, the DoN indicated that she did not interview any other residents or staff members about the above staff members to determine if their behavior was a pattern or if any other resident or staff members witnessed the "rude"		**4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** The Abuse CQI audit tool will be utilized weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less than 95%. **5. Date facility alleges compliance on July 11, 2012**	

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	behavior as indicated by Resident #156, but she will interview residents next time there is any type of an allegation. The DoN also indicated that she interviewed CNA #6 and CNA #7, while they were at work on 6/7/12 and 6/8/12, respectively. On 6/12/12 at 12:55 p.m., the DoN indicated that she didn't feel the allegations Resident #156 indicated were abuse, because Resident #156 indicated that CNA #6, CNA #7, and LPN #8 actions were rude, not their voice or tone. The DoN indicated that she would not want to be treated the way Resident #156 was treated. The DoN also indicated again that she was unsure if any resident interviews were completed for the investigation. She thought the Regional Social Services Consultant interviewed residents during their investigation, but the DoN was unsure. The DoN indicated that she does know the facility policy and knows that other residents are supposed to be interviewed. The Regional Social Services interviews were requested at this time. The Abuse Prohibition, Reporting, and Investigation Policy and Procedure also indicated that an investigation will be done to assure			

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	other residents have not been affected by the incident or inappropriate behavior and the results will be documented. The investigation will include facts and observations by witnessing non-employees and others who might have pertinent information. During an interview with the Administrator, on 6/12/12 at 1:35 p.m., he indicated that the investigation process, when an allegation of inappropriate behavior is reported, includes interviewing the resident, interviewing the implicated staff member(s), and interviewing other staff members and residents to determine if the allegation happened or if there is a pattern of inappropriate behavior. The Administrator also indicated that he would not like to be treated as the same way as Resident #156 was and he can see how rudeness can be a form of abuse. He also indicated that he was unsure if any resident interviews were completed for the investigation, but he said he was going to check to see if the Regional Social Services Consultant did some resident interviews. On 6/13/12 at 10:30 a.m., copies of the Facility's Social Services			

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	interviews with other residents regarding rude actions by CNA #6, CNA #7, and LPN #8, were provided. 3.1-28(a)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure a resident was dressed according to his accustomed preferences for 1 of 1 resident reviewed for choices. (Resident D) Findings include: During an interview with Family Member #11, who was also Resident D's Power of Attorney, on 6/6/12 at 1:15 p.m., she indicated the facility did not honor Resident D's preferences on how he dressed in that he wore mismatched clothing and no shoes. An observation of Resident D was made on 6/12/12 at 10:32 a.m. The resident was in an activity sitting in his Broda chair. Resident D was wearing a pair of faded, navy blue sweat pants with dried, crusted food residue on the left knee area, a white undershirt, and white socks with no shoes.	F0241	**F241 Dignity and Respect of Individuality** **It is the practice of this facilty to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition f his or her individuality.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident's care sheet was updated to reflect family's preference for resident's clothing. Customer Service representative identified and removed clothing items found to be in disrepair from resident's closet. The Guest Relations Coordinator will meet with resident's daughter, who lives out of state, during her next visit to review clothing preferences and ensure	07/11/2012

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	A second observation of Resident D was made on 6/13/12 at 10:05 a.m., again sitting in his Broda chair in an activity. He was observed wearing black warm-up pants, a white undershirt, white socks, and was wearing gym shoes. During a telephone interview with Family Member #11 on 6/13/12 at 10:42 a.m., she indicated Resident D would always wear casual clothes, like a polo shirt or dress shirt with trousers or khaki pants. She indicated she bought him these types of clothes in November, 2011. She indicated she bought about 6 outfits, "a whole new wardrobe." When told what Resident D was observed wearing that day and the previous day, she indicated he would never just wear an undershirt, would want to have shoes on, and would not wear sweat pants or warm up pants. At this time, an observation of Resident D's closet was made while Family Member #11 was on the telephone. Hanging in the wardrobe were several long sleeve shirts and polos, 3 white short sleeved undershirts, 1 orange t-shirt, a pair of blue and white pajama pants, 2 faded maroon sweats with holes near the pocket area, and blue shorts. Family Member #11 indicated, "My father		availability of preferred clothing items. **2. How will you identify other residents having the potential to be affected by these same deficient practices and what corrective action will be taken?** All residents have the potential to be affected. All staff in-servicing on Dignity is scheduled for July 10, 2012. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** During weekly customer care rounds and monthly customer care calls to POA's/families customer service representatives will inquire if clothing preferences have been honored and if it is found that any preferences have not been honored that information will be submitted as a grievance and followed up on through the grievance process.	

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	does not wear shorts. I have no idea where those came from. His summer clothes should be hanging, not winter." A clear garbage bag full of clothes was resting on the bottom of the wardrobe. An observation of Resident D's closet was made with the DON (Director of Nursing) on 6/13/12 at 1:30 p.m. During this observation, the clear garbage bag of clothing was opened and revealed 2 short sleeve polo shirts and 2 more short sleeved t-shirts (not white undershirts). The DON indicated she did not know why the bag of clothes was just lying in there and that she would get customer service to put them away. An interview with CNA #12 was conducted on 6/13/12 at 1:40 p.m. She indicated she asked Resident D what he wanted to wear that morning and he nodded his head yes to the white undershirt. At this time another observation of Resident D's closet was made. CNA #12 pointed out the 2 shirts she offered for Resident D to wear prior to the white undershirt. One was a long sleeve, flannel shirt. The other was a long sleeve collared shirt. The temperature that day, 6/13/12, reached a high of 80 degrees in Indianapolis, Indiana		**4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** A customer service audit tool will be utilized weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less than 95%. **5. Date facility alleges compliance on July 11, 2012.**	

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	according to weather.com. This federal tag relates to Complaint IN00108327. 3.1-3(t)			

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F0253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, interview, and record review, the facility failed to ensure a geri chair was clean and free of stains for 4 of 4 random observations involving Resident #2. Findings include: On 6/6/12 at 12:04 p.m., Resident #2's gerichair was observed with multiple whitish-tan stains/spots on both geri-chair arms. The stains/spots ranged from about dime size to about rice size. At 10:20 a.m., on 6/7/12, Resident #2's gerichair arms were observed with the same stains/spots as described above. Resident #2's geri-chair was observed, on Monday, 6/11/12 at 2:05 p.m., with the same spots as described as above. ON 6/13/12 at 1:40 p.m., Resident #2's geri-chair was observed with the same stains/spots as described as above on both arms.	F0253	**F253 Housekeeping and Maintenance Services** **It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident's chair was cleaned and a resident equipment cleaning event has been scheduled for July 9, 2012. **2. How will you identify other residents having the potential to be affected by**	07/11/2012

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	A review of the A/C Hall wheelchair cleaning list indicated that Resident #2's geri-chair was to be cleaned on Sunday, 6/10/12. In an interview with the Administrator on 6/13/12 at 1:45 p.m., he indicated that all wheelchairs and geri-chairs are to be cleaned by the night shift CNAs (certified nursing assistant), according to the schedule provided. The Administrator also indicated that when geri-chairs and wheelchairs are cleaned they are taken to the shower room and sprayed and wiped down. 3.1-19(f)		**these same deficient practices and what corrective action will be taken?** All residents who use wheelchairs for mobility have the potential to be affected. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A cleaning schedule has been implemented for weekly cleaning of resident personal equipment. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** DNS/Designee will audit for completion of the cleaning as scheduled weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less	

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			than 95%. **5. Date facility alleges compliance on July 11, 2012**	

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F0278 SS=A	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to document accurate information on the MDS for 1 of 43 residents reviewed for MDS (Minimum Data Set) accuracy. (Resident A) Findings include:	F0278	**F278 Assessment Accuracy** **It is the practice of this facility**	07/11/2012

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	The clinical record for Resident A was reviewed 6/8/12 at 10:30 a.m. The diagnoses for Resident A included, but were not limited to: compression fracture, back pain, and hip pain. The 4/9/12 Quarterly Review of the MDS (Minimum Data Set) indicated that Resident A did not receive PRN (as needed) pain medication. The April Physician's Orders included the following PRN (as needed) pain medications: Acetaminophen 325 mg (milligram), 2 tablets by mouth, every 6 hours, for mild pain or temperature greater than 100 degrees. Ibuprofen 400 mg, 1 tablet to be given every 4 hours, for headache. Pain Reliever Plus (no dosage indicated), 1 tablet is to be taken by mouth every 8 hours, for headaches. The April Medication Administration Record (MAR) was reviewed and the back side of the MAR included the documentation of the following PRN medications: 4/1/12 (no time indicated), ibuprofen (400 mg) was given for a complaint of a headache. 4/5/12, acetaminophen (650 mg), was		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **The MDSC transmitted a modification to the MDS on 6/11/12** **2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?** **All residents have the potential to be effected** **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** **The MDSC and MDSCA will alternate all MDS assessment assignments which will allow**	

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	given for a complaint of pain in Resident A's back and a headache. 4/7/12, ibuprofen 400 mg, was given at 11:00 a.m. and again at 3:00 p.m., for a complaint of back pain. 4/7/12 at 8:30 a.m., Pain Reliever Plus was given for a compliant of a headache. On 6/11/12 at 10:15 a.m., the MDS coordinator indicated that the look back period for the MDS review was 7 days prior to 4/9/12. She also indicated that headaches are considered pain and that the MDS answer, with no PRN pain medication given, was incorrect. 3.1-31(d)		**them to audit each other's completed work for accuracy, which will allow for a second check of each MDS before transmission** **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** **RAI consultant/ED designee will conduct a monthly MDS audit for accuracy** **5. The facility alleges date of compliance on July 11, 2012.**	

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F0280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review, and interview, the facility failed to ensure care plans were updated for pressure ulcer treatment, fall prevention, and pain management, for 2 of 43 residents reviewed for care plans. (Resident #174 and C) Findings include: 1. Resident #C's clinical record was reviewed on 6/8/2012 at 2:05 p.m. Diagnoses included but were not limited to; iron deficiency anemia, dementia, Alzheimer's disease, hypertension, venous thrombosis	F0280	**F280 Participate in Planning / Revising Care Plan** **It is the practice of this facility for the resident to participate in planning care and treatment or changes in care and treatment.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Both residents' care plans were reviewed and updated for appropriateness and	07/11/2012

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	(blood clot in vein). A care plan, dated 6/22/2011, indicated, "Problem: Potential for skin breakdown related to cerebral vascular accident (stroke), anemia, decreased mobility, bowel incontinence, and resident refuses care. Goal: Will have no skin breakdown. Approach dated 5/23/2012: Heels up while in bed at all times while in bed. Approaches dated 6/22/2011; Assist resident with toileting and peri care after each incontinent episode. CNA to do skin check with shower and notify LN (licensed nurse) of abnormals. Diet/supplements as ordered. Encourage 75 to 100% meal/ fluid consumption and monitor consumption. Pressure reducing/redistribution mattress on bed. Pressure ulcer risk assessment. Turn and reposition at least every 2 hours and prn (as needed). Weekly skin checks by LN." A nursing note, dated 5/23/12 at 2:21 a.m., indicated, "....Stage 2 pressure area noted to right outer heel measuring approximately 0.7 by 0.4 by 0.1. Physician notified/ treatment to be done per orders. Family to be notified by dayshift...."		effectiveness of interventions. **2. How will you identify other residents having the potential to be affected by these same deficient practices and what corrective action will be taken.** All residents have the potential to be affected. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** New orders and fall interventions will be reviewed in the clinical meetings and will be added to residents' care plans. In-servicing on plan of care updating is scheduled for July 10, 2012. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	Interview with the ADON (Assistant Director of Nurses) on 6/11/2012 at 2:32 p.m., indicated the 5/23/2012 nursing note regarding the stage 2 pressure area to the resident's right heel was the first time it was found and the wound was currently healing and improving. Observation of Resident #C's wound on 6/12/2012 at 10:44 a.m., while the resident was sitting up in her wheelchair in her room indicated the wound was on her right outer heel. It was the size of a pencil eraser and black in color. The wound had no drainage or redness surrounding the tissue. The wound was open to air. Review of a treatment administration record, dated 5/25/2012, indicated, "Clean right heel area with dermal wound cleanser then apply fluffed gauze with hydrogel to wound base, cover with dry gauze-secure with Kerlix. Change daily/ as needed with soilage or displacement." The care plan was not updated to include the treatment of the pressure ulcer. 2. The clinical record for Resident #174 was reviewed on 6/7/12 at 3:30 p.m.		**assurance program will be put in place?** The Care Plan Updating CQI audit tool will be utilized weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less than 95%. **Date facility alleges compliance on July 11, 2012.**	

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The diagnoses for Resident #174 included, but were not limited to: dementia unspecified, with behavior disturbances, hypertension, and congestive heart failure.

An intervention on a fall care plan, dated 5/29/12, indicated a protective safety helmet was to be utilized while the resident was up in a wheelchair.

During an observation of Resident #174, on 6/6/12 at 9:30 a.m., he was in his wheelchair in the dining room and he was not wearing his protective helmet.

In an interview with PT (Physical Therapist) #3, on 6/8/12 at 1:00 p.m., she indicated that the resident is supposed to be wearing his helmet while he is in his wheelchair, but he is very non-compliant and will take it off as he pleases. She also indicated that she will notify nursing that the care plan needs to be revised, in regards to the resident being non-compliant with the fall intervention.

At 1:20 p.m. on 6/8/12, Resident #174's family member indicated the resident doesn't always wear his helmet when in his wheelchair and

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	that staff don't always put it on him when he is up in the wheelchair. On 6/8/12 at 2:25 p.m., the resident was up in his wheelchair eating lunch. The resident was not wearing his helmet. The DoN (Director of Nursing) indicated on 6/11/12 at 11:30, that if an intervention on a care plan isn't working then the care plan should be revised. 3.1-35(d)(2)(B)			

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F0309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure effective pain management was implemented for 3 of 3 residents reviewed in a sample of 43, who met the criteria for pain management (Resident A, #22, and #71). Findings include: 1. The clinical record for Resident A was reviewed 6/8/12 at 10:30 a.m. The diagnoses for Resident A included, but were not limited to: compression fracture, back pain, and hip pain. In an interview with Resident A on 6/5/12 at 10:26 a.m., Resident A indicated that she was having pain in their left hip and she was given pain medication a little earlier that day. Resident A was unsure of what pain medication was given to her.	F0309	**F309 Provide Care/Services For Highest Well Being** **It is the practice of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The residents were reassessed for pain and the physician was notified of the changes in	07/11/2012

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	The April, May, and June Physician's Orders included the following PRN (as needed) pain medications: Acetaminophen 325 mg (milligram), 2 tablets by mouth, every 6 hours, for mild pain or temperature greater than 100 degrees. Ibuprofen 400 mg, 1 tablet to be given every 4 hours, for headache. Pain reliever plus (Excedrin) (no dosage indicated), 1 tablet is to be taken by mouth every 8 hours, for headaches. The following dates on the April, May, and June MAR (Medication Administration Record), indicated that acetaminophen (650 mg) was given: 4/2/12, 4/4/12, 4/8/12, 4/13/12, 5/1/12, 5/2/12, 5/3/12, 5/5/12 5/7/12, 5/8/12, 5/9/12 (x 2), 5/11/12, and 6/2/12. On the following dates on the April, May, and June MAR, it indicated that ibuprofen 400 mg was given: 4/3/12, 4/4/12, 4/8/12, 4/10/12, 4/11/12, 4/12/12, 4/13/12, 4/15/12, 4/16/12, 4/17/12, 4/18/12, 4/19/12, 4/21/12, 4/24/12, 5/4/12, 5/8/12, 5/9/12, 5/12/12, 5/13/12, 5/25/12, 5/26/12, 6/2/12, 6/5/12, and 6/6/12. The following dates on the April and May Mar indicated the Pain Reliever		condition. All prn pain medication orders will be audited for frequency, of use, need for continued use and the presence of a current pain assessment **2. How will you identify other residents having the potential to be affected by these same deficient practices and what corrective action will be taken?** All residents with PRN pain medication have the potential to be affected. In-service is scheduled for nurses on July 10, 2012 to review proper procedure for assessment of pain before and after PRN medication administration. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/Designee will monitor the MAR M-F for proper documentation related to the assessment of the residents' pain before and after medication	

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	Plus was given: 4/2/12, 4/3/12, 4/4/12, 4/6/12, 4/10/12, 4/11/12, 4/12/12, 4/13/12, 4/15/12, 4/16/12, 4/17/12, 4/18/12, 4/19/12, 4/21/12, 4/24/12, 5/1/12, 5/2/12, 5/3/12, 5/4/12, 5/5/12, 5/7/12, 5/8/12, 5/9/12, 5/12/12, 5/14/12, 5/18/12, 5/21/12, 5/22/12, 5/23/12, and 5/26/12. In a review of the April, May, and June Nursing Notes and the front/back of the April, May and June MARs, there was no indication for the use of the PRN pain medication administered on the above dates. Also, there no pre-assessment or post assessment of pain after the PRN pain medication was administered on the above listed dates. In an interview with the DoN (Director of Nursing), on 6/11/12 at 2:00 p.m., she indicated that she was unable to determine if non-pharmacological interventions were used prior to medication administration or if pain was assessed prior/after the pain medication was administered on the above dates. An intervention, on a care plan for pain, dated 6/23/12, indicated the MD (Medical Doctor) was to be notified if pain is unrelieved.		administration. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** The pain management CQI audit tool will be utilized weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less than 95%. **5. Date facility alleges compliance on July 11, 2012.**	

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On 1/16/12, a NP (Nurse Practitioner) Visit Note, indicated that chronic pain and headaches were addressed at a visit with Resident A.

The DoN indicated on 6/12/12 at 3:30 p.m., that chronic pain was not addressed again until 5/11/12, when a Physician Telephone Order indicated that an x-ray was to be obtained for back pain.

2. The clinical record for Resident #71 was reviewed on 6/11/12 at 1:30 p.m.

The diagnoses for Resident #71 included, but were not limited to: aortic stenosis, history of syncope, and neuropathy.

During an interview with Resident #71 on 6/6/12 at 10:26 a.m., she indicated she'd been having discomfort such as pain, heaviness, burning, or hurting with no relief. She indicated at night, the bottom of her feet were hot and burning.

The 11/3/11 pain care plan indicated Resident #71 was at risk for pain related to decreased mobility and history of complaints of shoulder and

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	arm pain. During an interview with LPN #5 on 6/12/12 at 1:32 p.m., she indicated Resident #71 had chronic pain and little aches, maybe in her neck, if she slept wrong. She indicated she hadn't noticed any worsening pain in Resident #71. No other areas of pain were mentioned by LPN #5. When queried about any other pain Resident #71 may have, she indicated, "She would tell me if there was pain we didn't know about." At this time, the complaint of pain/burning on the bottom of Resident #71's feet was brought to the attention of LPN #5. LPN #5 indicated the resident did, in fact, inform about the pain on her feet a couple of months ago. The 4:00 a.m., 2/9/12 nurses note was reviewed with LPN #5 and indicated, "Resident (symbol for "with") c/o (complaint of) pain to posterior aspects of bilateral feet. Areas assessed no anomalies noted. Resident states pain occurs primarily during noc (night) hours (symbol for "and") has been increasing in pain (symbol for "and") intensity over the last several weeks. Also states pain has been disrupting sleep...MD (name of MD)'s office notified of			

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	above c/o (complaints) (symbol for "and") requested to evaluate resident on next rounds." The 11:00 a.m., 2/9/12 nurses note indicated, "res (resident) cont (continues) c/o (complaints) intermittant [sic] pain to bottoms of bilateral feet..." There was no information in the clinical record to indicate Resident #71 was seen on the next rounds regarding the burning on the bottom of her feet. LPN #5 indicated she would look into this further for any follow through. During an interview with the DON (Director of Nursing) on 6/13/12 at 10:45 a.m., she indicated the next doctor rounds to occur after 2/9/12 was on 2/10/12 and there was no information to indicate Resident #71 was seen on the 2/10/12 round regarding the pain in her feet. She indicated if there was any follow through at that time, there was no verification. She indicated she would have expected the doctor to see her on the 2/10/12 rounds. She indicated she was not aware of any system their facility had in place to ensure the doctor's office followed through with			

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	issues brought to their attention. The 6/8/12 podiatry progress note was reviewed and indicated "Subjective: burning pain bottom of feet. History of Present Illness: admits to increasing pain bottom of feet burning in nature (symbol for greater than) 6 months duration. Pain has increased over that time frame. Gets worse @ night in bed. Notes/Orders: recommend Rx (prescription) Neurotin (medication taken for neuropathy)." No information could be found in the clinical record to indicate the above prescription was ordered for Resident #71 until 5 days later on 6/13/12, after this issue was brought to the attention of the facility staff on 6/12/12. The 6/13/12 physician's progress note indicated, "Foot pain...Says her foot pain worse at night. Shooting type pain...Pain needs help. Assessment: Neuropathy. Plan: Start Neurotin." Resident #71 was diagnosed with neuropathy on 6/13/12 and prescribed the podiatry recommended medication for this disease.			

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	3. The clinical record for Resident #22 was reviewed on 6/11/12 at 1:00 p.m. The diagnoses for Resident #22 included, but were not limited to: osteoarthritis, morbid obesity, and degenerative joint disease. The June, 2012 physician's recapitulation orders for Resident #22 indicated one 5-325 tab of hydrocodone to be given by mouth every 4 hours as needed for moderate pain. The June, 2012 MAR (Medication Administration Record) for Resident #22 indicated hydrocodone was given twice on 6/12/12, three times on 6/11/12, and twice on 6/8/12. There was no information in the clinical record to indicate the resident was assessed for the location or intensity/nature of the pain prior to administering the pain medication or for the effectiveness of the medication after the medication was given. During interview with LPN #1 on 6/12/12 at 12:40 p.m., she indicated, "I forgot to document one time, sorry. I'll do it right now." She proceeded to document the back of the MAR with a			

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	6/11/12 entry for a hydrocodone administration. During interview with the DON 6/12/12 at 12:52 p.m., she indicated there was no information to indicate a pre-assessment or post assessment for pain was done on the above dates. She stated, "It looks like night shift has a problem with this." 3.1-37(a)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review, interview, and observation, the facility failed to ensure pressure ulcer prevention related to ill-fitting shoes for 1 of 4 residents reviewed for pressure ulcers. (Resident #C) Findings include: Resident #C's clinical record was reviewed on 6/8/2012 at 2:05 p.m. Diagnoses included but were not limited to; iron deficiency anemia, dementia, Alzheimer's disease, hypertension, venous thrombosis(blood clot in vein). A care plan, dated 6/22/2011, indicated, "Problem: Potential for skin breakdown related to cerebral vascular accident (stroke), anemia, decreased mobility, bowel incontinence, and resident refuses care. Goal: Will have no skin	F0314	**F314 Treatment/Svcs To Prevent/Heal Pressure Sores** **It is the practice of this facility to provide comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.**	07/11/2012

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	breakdown. Approach dated 5/23/2012: Heels up while in bed at all times while in bed. Approaches dated 6/22/2011; Assist resident with toileting and peri care after each incontinent episode. CNA to do skin check with shower and notify LN (licensed nurse) of abnormals. Diet/supplements as ordered. Encourage 75 to 100% meal/ fluid consumption and monitor consumption. Pressure reducing/redistribution mattress on bed. Pressure ulcer risk assessment. Turn and reposition at least every 2 hours and prn (as needed). Weekly skin checks by LN." Review of resident progress notes indicated weekly skin assessments were completed on 5/9/12 at 2:24 a.m. and 5/23/12 at 2:21 a.m. There was no assessment for 5/16/2012. A nursing note, dated 5/23/12 at 2:21 a.m., indicated, "....Stage 2 pressure area noted to right outer heel measuring approximately 0.7 by 0.4 by 0.1. Physician notified/ treatment to be done per orders. Family to be notified by dayshift...." Interview with the ADON (Assistant Director of Nurses) on 6/11/2012 at 2:32 p.m., indicated, "weekly skin		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Appropriate fitting footwear provided for resident. **2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All new admits will be assessed for appropriate fitting footwear utilizing a Brannock device.	

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	checks are the expectation of the nurses." He didn't know why there were no nursing notes or weekly skin check documented on 5/16/2012. The ADON stated, "The 5/23/2012 nursing note regarding the stage 2 pressure area to her right heel was the first time it was found. The wound is currently healing and improving." He indicated he had not yet personally observed the wound. Observation of Resident #C's wound was made on 6/12/2012 at 10:44 a.m., with ADON present. The resident was in her room and sitting up in her wheelchair. Resident #C's wheelchair did not have foot pedals attached, she had on socks with no shoes, and her feet were dangling. The ADON removed her right sock and her wound was observed on her right outer heel. The wound was the size of a pencil eraser and black in color, and there was no drainage or redness surrounding the black tissue. The wound was left open to air until a sock was put back on by the ADON. He indicated that the resident's dressing changes are completed in the early a.m. and that he had just removed the dressing prior to the observation. He offered to take Resident #C back to activities. The resident was wearing socks but no		In house residents will be assessed quarterly for appropriate fitting footwear utilizing a Brannock device. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?** The Skin Management Program CQI tool to be completed weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less than 95%. **5. The facility alleges date of compliance on July 11, 2012.**	

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	shoes when she left the room. Review of a MDS assessment, dated 3/12/2012, indicated the resident required extensive assistance for dressing. The resident was able to be involved in activity, staff provided weight bearing support requiring one person physical assistance for dressing which is defined by how the resident puts on, fastens and takes off all items of clothing. Review of a Treatment Administration Record (TAR), dated 5/25/2012, indicated, "Clean right heel area with dermal wound cleanser then apply fluffed gauze with hydrogel to wound base, cover with dry gauze-secure with Kerlix. Change daily/ as needed with soilage or displacement." No original MD order documentation could be found. Interview with the DON on 6/13/2012 at 2:00 p.m., indicated she was unable to find the original MD order for the right heel wound treatment. During observation of Resident # C on 6/13/2012 at 10:40 a.m., the resident was still asleep in her room in her wheelchair. There were no foot pedals on the chair and she was wearing socks without shoes. Her toes were touching the ground, but			

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	the middle of her feet and heels were suspended in the air. Interview with ADON on 6/13/2012 at 11:10 a.m., indicated, "Resident #C's old shoes were what caused the pressure ulcer on her right outer heel." He considered it to be healed now since it is not causing her any discomfort, this was why he didn't redress the wound. "Resident #C has since gotten new shoes and so maybe she hasn't been wearing them because it's a possibility the CNA's don't know she has new ones. The resident ideally should be wearing these new shoes." He indicated he wasn't sure why she didn't have foot pedals on her wheelchair but he would take care of this and put her shoes on right away. He indicated he didn't think her not wearing shoes would cause any concern for her skin integrity on her feet." The federal tag relates to Complaint IN00108327. 3.1-40(a)(1)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to provide an indication for PRN (as needed) anti-anxiety medication administration and provide non-pharmaceutical interventions prior to anti-anxiety medication administration for 1 of 10 residents reviewed for unnecessary medication. (Resident #44) Findings include: The clinical record for Resident #44	F0329	**F329 Drug Regimen is Free From Unnecessary Drugs** **It is the practice of this facility to provide each resident's drug regimen must be free from unnecessary drugs.** **1. What corrective action(s) will be accomplished for those residents found to have been**	07/11/2012

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	was reviewed on 6/7/12 at 2:50 p.m. The diagnoses for Resident #44 included, but was not limited to: anxiety, depression, and end stage renal disease. The April and May Physician's Orders indicated an order for a half of a tablet of 0.5 mg (milligram) clonazepam (anti-anxiety medication) to be taken by mouth every 12 hours PRN (as needed). An intervention, dated 3/22/12, on care plan for the use psychotropic medications, indicated that medications are to be administered as ordered and observed for effectiveness. The April and May MAR (Medication Administration Record) indicated that Resident # 44 took a half a tablet of 0.5 mg PRN clonazepam on the following dates: 4/6/12, 4/11/12, 4/19/12, 4/24/12, 5/8/12, 5/10/12, 5/12/12, 5/16/12, 5/25/12, 5/26/12, 5/29/12, and 5/30. There was no indication, in the Clinical Record including the Nurse's Notes and on the front/back of the April and May MARs, for the use of the medication for the above dates.		**affected by the deficient practice?** Resident's physician was notified regarding the frequency of use of PRN clonazepam for this resident **2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?** All residents on PRN medications have the potential to be effected. Nurses will be in-serviced on July 10, 2012 about proper procedures for attempting non-pharmacological interventions and documentation of the interventions prior to the administration of PRN psychoactive medications and documentation indicating the need for medication and the resident's response to the medication. They will also be in-serviced on facility's new procedure for calling the DNS/Designee prior to the administration of PRN psychoactive medications.	

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	Also there was no indication that any non-pharmacological interventions were utilized for the above dates. On 6/8/12 at 1:00 p.m., the DoN (Director of Nursing) indicated that she was unable to determine if any non-pharmacological interventions were used or why the medication was given on the above dates. 3.1-48(a)(4)		**3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Audit all residents on PRN medications for frequency of usage and need for continued usage. Monthly pharmacy consultant will audit PRN medication usage monthly. DNS or designee contacted prior to PRN psychoactive medication administration. Pain assessment completed for all new onset pain. All non-pharmacologic interventions will be documented prior to PRN medication administration. Indications for and effectiveness of PRN medication will be documented. Corrective action up to and including termination for staff not complying with corrective measures. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put in place? Unnecessary Medication CQI tool to be completed weekly X4, bimonthly X4 then quarterly thereafter. Corrective Action Plan will be completed for compliance less than 95%. **5. The facility alleges date of compliance on July 11, 2012.**	

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F0364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to ensure food served from the kitchen was palatable, attractive, and served at a preferable temperature. This affected 9 of 14 residents interviewed for food quality. (Resident #177, 148, 166, 143, 83, 56, 156, 66 and 86) Findings include: 1. At 9:28 a.m. on 6/5/12, Resident #148 indicated the food had no flavor and meals were not always served at the appropriate temperature. On 6/5/12 at 10:27 a.m., Resident #143 indicated that meals were rarely served at the proper temperature. On 6/5/12 at 12:54 p.m., Resident #177 indicated the food had no flavor and was always the improper temperature when served.	F0364	**F364 Nutritive Value/Appearance, Palatable/Prefer Temp.** It is the practice of this facility to provide food that has a nutritive value and appearance and is palatable and at a preferred temperature **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents noted to be affected by the deficient practice will be monitored for 3 random meals weekly by assigned members of the IDT. · Any identified issues will be resolved promptly in accordance with dietary guidelines and MD orders.	07/11/2012

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	During interview with Resident # 56 on 6/5/2012 at 1:08 p.m., Resident #56 indicated the food did not taste good and look appetizing. Resident #166 indicated on 6/6/12 at 10:39 a.m., the food was almost always served at the inappropriate temperature. During an interview with Resident #86 on 6/6/12 at 11:22 a.m., he indicated his breakfast was always cold. During interview with Resident # 83 on 6/6/2012 at 11:51 a.m., Resident #83 indicated the food did not taste good and look appetizing nor was it served at the proper temperature. He stated, "It's ice cold." At 11:55 a.m., on 6/6/12, Resident #156 indicated the meals were never served at an appropriate temperature. During an interview with Resident #66 on 6/11/12 at 3:18 p.m., regarding her lunch, she indicated her food did not taste good, was not full, and was dissatisfied.		**2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?** All residents who participate in dining meal service have the potential to be affected. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · A dining room monitoring schedule has been put into place to ensure timely meal tray delivery, food appearance and palatability. · New insulated hall carts are being used to deliver meal trays to the halls. · Dietary will be in-serviced on correct methods of following the recipes, and correct monitoring of food holding temperatures.	

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BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN 46107

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	2. A test tray was observed on 6/7/12 at 12:50 p.m. The tray consisted of sloppy joe, potato chips, and cucumber salad. The sloppy joe tasted lukewarm, at best. A second test tray was observed on 6/8/12 at 12:55 p.m. The tray consisted of a western burger, onion rings, and mixed fruit. The burger and onion rings tasted room temperature and bland. 3.1-21(a)(2)		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Dietary Manager or Designee will complete the CQI Meal Service Form 5 days per week for two weeks, then three times a week for 2 weeks then weekly for 4 weeks. · Test trays will be sampled weekly for eight weeks by members of the IDT. · Results of these audits will be forwarded to the monthly CQI Meeting. **5. The facility alleges date of compliance on July 11, 2012.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING _____ B. WING 00	06/13/2012

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F0465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the kitchen was kept in a clean, sanitary condition during 2 of 2 kitchen observations. Findings include: An observation of the entire kitchen was made on 6/4/12 at 12:00 p.m. Upon entrance to the kitchen, one's feet began to stick to the floor with each subsequent step, enabling the sound of a shoe peeling off the floor. Underneath the dishwasher area wet, mushy looking debris was observed on the floors and around cream colored pipes. The stench of old food permeated the air. A second observation of the kitchen was made on 6/7/12 at 11:27 a.m. A quarter size glop of food was stuck to the floor between the bin of bread crumbs and bin of oats in the dry storage area. A gnat was observed flying over a pan of discarded cucumber salad next to the dishwasher. A mat placed in front of the dishwasher was observed with wet, mushy debris stuck in the	F0465	**F465 SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT** It is the practice of this facility to provide a safe, functional, sanitary, comfortable environment. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The floor has been deep scrubbed on June 27, 2012. · The dish machine drain was resealed to stop the leak on the floor. **2. How will you identify**	07/11/2012

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	crevices. The gunk remained around the cream colored pipes underneath. During an interview with the Dietary Manager on 6/7/12 at 11:30 a.m., she indicated the floors were cleaned after every meal. She indicated her expectation was for floors to be cleaned under kitchen appliances like the dishwasher and stoves. She indicated the dishwasher area was mopped that day about an hour ago, at 10:30 a.m., but they didn't do a very good job because she could see stuff underneath on the floor. She indicated they should be sweeping and mopping every shift underneath everything. She pointed to the metal portion of the dishwasher area where trays are pushed through and indicated it was not attached to the wall like it should be, enabling water to drip down the wall and onto the floor. Puddles of water were observed resting underneath the pipes under the dishwasher. During interview with Dietary Aide #10 on 6/7/12 at 11:43 a.m., he indicated he mopped the dishwasher area after breakfast, but did not mop as far as he could reach. During interview with the Dietary Manager on 6/7/12 at 11:40 a.m., she		**other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?** No residents are at risk by this practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Floor machine scrubbing will be added to the deep clean schedule on a monthly basis. · Kitchen staff will be in-serviced regarding proper cleaning procedures. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Dietary Manager or	

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	indicated she was the one who mopped under the stove area and that she did not mop as far as she could reach. During another interview with the Dietary Manager on 6/8/12 at 11:50 a.m., she indicated there was, in fact, a leaky pipe under the dishwasher area and that someone was coming in to fix it. She stated, "We also deep cleaned the floors. They look great." 3.1-19(f)		Designee will complete 5 days per week the “Short Sanitation Inspection” for 2 weeks and then 3 days per week for 2 weeks and then weekly for 4 weeks. · Results of these audits will be forwarded to the monthly CQI Meeting. **5. The facility alleges date of compliance on July11, 2012.**	